HIPAA INTERACTION MODEL
USER GUIDE

Introduction

Washington State Department of Health (DOH) and Department of Social and Health Services (DSHS) collaborated on this document after discovering that the respective departments had many inter-relationships that were not easily classified under the HIPAA regulation. After documenting several of these relationships, it was clear that a more generic "model" would help in classifying similar relationships found throughout our government system.

Usage Guidance

Our intent is to provide a document that we can use to compare these models with other programs' functions and have an analytical tool for beginning HIPAA assessment of those programs. We anticipate documenting additional models as we find them. We also anticipate that this document is helpful to other, similar government programs in their HIPAA efforts. However, this tool is not a comprehensive or "stand alone" document by which to determine HIPAA status and compliance.

Regarding Entity Status, note that your program may perform additional or different functions or be structured differently so as to impact entity status. Also, legal compliance requirements may not unconditionally make a program subject to all HIPAA requirements. If the entity does not perform or is not responsible for covered functions, or does not maintain or transact anything containing PHI, then the actual impact of the HIPAA requirements may be limited or minimal. (An example is Jointly Administered Government Programs).

Regarding Compliance Status, a program that is not legally required to comply may have other considerations that push towards compliance which will differ with each individual program.

Model Types

Models A through F are all program interactions with Medicaid. Additional models are anticipated.

Model A—Not Medicaid Directed: Reimbursed for Services that impact Medicaid Population

Model B— Medicaid Interaction - Administration and Operations: No Transactions

Model C—Medicaid Interaction - Administration and Operations: With Eligibility and Enrollment Transactions

Model D—Medicaid Interaction - Administration and Operations: With Transactions other than Eligibility and Enrollment

Model E—Medicaid Interaction - Jointly Administered: Transactions or Protected Health Information

Model F—Medicaid Interaction - Jointly Administered: No Transactions or Protected Health Information

Model G – Part of State Medicaid Agency: No Medicaid funds or participation.

Model H –Local Government Interaction – Grant Award

Model Structure

The model has the following components:

1. Describe common interactions that government programs share (Program Description)

   The first models are focused on programs that interact with Medicaid. These interactions raise particular issues because of Medicaid's status as a named health plan under HIPAA, and whether that status has an impact on other programs and activities that have a relationship with Medicaid. More programs will be added as other common interactions are found. The impact of HIPAA on these programs may differ depending on the covered entity status and type of the participants as well as the relationships between them.

2. Identify the level of legal compliance required by HIPAA (Entity Status)

   The entity status of the program is an evaluation of the program's status under HIPAA and is divided into categories using the major HIPAA "players" as described or defined in the regulatory text and comments. They are: Health Plan, Health Care Provider, Clearinghouse, business associate, sponsor, Jointly administered government program, and not a covered entity. Please see Appendix for more information on these entities.

3. Identify what level of business compliance is required or advisable (Compliance Status)

   The compliance status of the program is an evaluation of the functions, relationships, political or public issues, legal compliance category, and other factors to determine whether the entity has business needs that would necessitate compliance with part or all of HIPAA. These categories are: Required to Comply, Compelling/Urgent Need, Good Business Practice, Indirect Impact, No requirement/No Impact. Please see Appendix for more information on these categories.

4. Identify examples that meet the general program description

   The program examples are examples that we have identified that fit the pattern described in the general program description and are used to explore the compliance status and any additional variations that may be present.

5. Appendix

   The appendix provides a more in depth description of Key Terms found in the Model, an overview of HIPAA implications for the various status Terms, and references.

Authors

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Interaction Model A

Program with Medicaid Interaction	HIPAA Entity Status	Compliance Status
Not Medicaid Directed. Reimbursed for Services to Medicaid Population Description: The program does not perform health care provider or health plan functions. The program is outside of the Medicaid Entity and works independent from Medicaid in all daily operations. Because the services benefit a part of the Medicaid population or are also used by the Medicaid population the program is eligible for Medicaid matching funds. Conclusion: The program is not performing a Health Plan or health care provider function, and is not a business associate of a covered entity. Because the program is not Medicaid (not directed by nor performing a function on behalf of) and works independently from Medicaid and other programs, it is not a jointly administered government program.	☐ Health Plan ☐ Health Care Provider ☐ Clearing House ☐ Business Associate ☐ Sponsor ☐ JAGP ■ Not Covered	☐ Required to Comply ☐ Compelling / Urgent Need ☐Good Business Practice ☐ Indirect Impact ☐ No Requirement / No Impact
Program Examples		
Example 1 *A DOH program, Child Profile provides on-line, child specific immunization records to physicians and clinics across the state. Medicaid children are estimated to make up 21% of the child age population in Washington. Medicaid (DSHS)agrees to reimburse 21% of the Child Profile costs.*	■ Not Covered	■ Indirect Impact

Notes:
These programs have no legal requirement to comply with HIPAA. However, other federal or state programs that contribute funding (such as Medicaid) may require a certain level of HIPAA compliance as a condition of participation.

Interaction Model B		
Program with Medicaid Interaction	**HIPAA Entity Status**	**Compliance Status**
Administration and Operations – No Transactions Description The program is outside of the Medicaid Entity. The program performs an administrative or operational role for a Medicaid program, which may include some health plan functions, but does not conduct any HIPAA covered transactions. Conclusion: The program is performing a function for a health plan (Medicaid) and therefore is its business associate.	☐ Health Plan ☐ Health Care Provider ☐ Clearing House ■ Business Associate ☐ Sponsor ☐ JAGP ☐ Not Covered	☐ Required to Comply ☐ Compelling / Urgent Need ☐ Good Business Practice ☐ Indirect Impact ☐ No Requirement / No Impact
Program Examples		
Example 1 *Maternity Support Services (MSS), a DSHS program, provides public health nursing, nutrition, and psychosocial visits to Medicaid eligible pregnant and postpartum women. Services are provided through agencies with DSHS-MAA core provider agreements. The DOH MSS office reviews all new providers and recommends to DSHS whether the provider should be granted a DSHS core provider agreement. Thereafter, DOH monitors the provider for compliance with DSHS requirements. DOH has no other interaction with the providers or the patients who receive their services. DOH is reimbursed 50% or 75% by DSHS for costs of administration and operations.* *Example 2* *DOH program, MCH Assessment unit, provides statewide, statistical and aggregate evaluation of health care services need, supply, impact, and effectiveness. Time spent on assessment activities for Medicaid populations are reimbursed on a 50/50 match.*	■Business Associate ■ Business Associate	■ Indirect Impact ■ No Requirement – No Impact
Notes: This could be considered a Jointly Administered Government Program (JAGP). However, the DOH program appears to more closely perform the functions of a business associate because it adheres to DSHS criteria in reviewing and monitoring contractors. Also considered whether this activity falls under “oversight” as defined in HIPAA. This program does oversee the qualifications of healthcare providers and monitors their compliance to DSHS criteria. However, the program does not perform independent review or evaluation of providers for purposes other than compliance with DSHS criteria.		

Interaction Model C		
Program with Medicaid Interaction	**HIPAA Entity Status**	**Compliance Status**
Administration and Operations – With Eligibility and Enrollment Transactions Description: The program is outside of the Medicaid Entity. The program performs an administrative or operational role for a Medicaid program. It conducts eligibility or enrollment transactions only. Conclusion: HIPAA regulation comments explicitly exclude eligibility or enrollment determination by a program not otherwise covered, but do not explicitly indicate that the program is not acting on behalf of Medicaid.	☐ Health Plan ☐ Health Care Provider ☐ Clearing House ■ Business Associate ☐ Sponsor ☐ JAGP ■ Not Covered	☐ Required to Comply ☐ Compelling / Urgent Need ☐Good Business Practice ☐ Indirect Impact ☐ No Requirement / No Impact
Program Examples		
Example 1 Local welfare offices collect financial information from TANF clients and determine if a client meets the financial eligibility for Medicaid. If so, the information is forwarded to the Medical Assistance Administration, who determines programmatic eligibility. Note that this illustrates the impact of this function only. If the welfare office otherwise provide or pay the cost of health care or perform other function, they may be a covered entity. The welfare office may have to change the content of the information collected so that Medicaid has HIPAA compliant data. The privacy regulation states that no business associate contract is required for this function.	■ Business Associate ■ Not Covered	■ Good Business Practice
Notes: Caution should be exercised to ensure that criteria are met for the exception, and that other functions are not performed or are covered by an appropriate entity relationship. "A government agency that is not otherwise a covered entity does not become a covered entity simply because it determines eligibility or enrollment or collects protected health information as authorized by law for covered government programs." 65 CFR 82479, 82504, 82578. A specific exception to the privacy regulation for use and disclosure of this information is found at §164.504(e)(1)(ii)(C). The comment states that an agency not otherwise covered does not become covered by performing this function, however there is no correlating exception for the Medicaid or other payer. Thus, the agency performing the function may not be a covered entity, but may be acting on behalf of the Medicaid agency, and will be required to conduct the transaction accordingly. While excluded as a covered transaction, the information must still contain data that will enable the covered government program to comply with HIPAA and programs must be cognizant of the confidential nature of the health information. Public expectation and industry standard may drive the same or similar privacy protections of the welfare office as it would had the client gone directly to the medical administration because the content and purpose of the information is the same.		

Interaction Model D		
Program with Medicaid Interaction	**HIPAA Entity Status**	**Compliance Status**
Administration and Operations – With Covered Transactions other than Eligibility and Enrollment Description: The program is outside of the Medicaid Entity. The program performs an administrative or operational role for a Medicaid program and conducts HIPAA covered transactions other than eligibility or enrollment. Conclusion: Programs that conduct a HIPAA covered transaction for Medicaid are acting on behalf of Medicaid and are therefore a business associate	☐ Health Plan ☐ Health Care Provider ☐ Clearing House ■ Business Associate ☐ Sponsor ☐ JAGP ☐ Not Covered	☐ Required to Comply ☐ Compelling / Urgent Need ☐Good Business Practice ☐ Indirect Impact ☐ No Requirement / No Impact
Program Examples		
Example 1 *Community Aids Service Alternatives program determines eligibility of CASA claims for persons who have previously qualified as DSHS CASA eligible. CASA is a Medicaid Waiver program. Paper claims are received by the CASA program and are reviewed to determine if the claim is included in the covered benefits. If covered, the claim is pre-authorized and forwarded to Medicaid for payment in the MMIS system with a CASA specific service code (Referral Certification and Authorization (278) Transaction).*	■Business Associate	■ Required to Comply
Notes: This could be considered a Jointly Administered Government Program (JAGP). However, the DOH program appears to more closely perform the functions of a business associate because it adheres to DSHS specified program criteria and performs a small part of the overall program. Finally, either designation would lead to the same result – the program is required to comply with HIPAA for the covered functions it performs.		

Interaction Model E		
Program with Medicaid Interaction	**HIPAA Entity Status**	**Compliance Status**
Jointly Administered—With Transactions or Health Information Description: Non-State Medicaid program participates in a Medicaid program by setting policy, providing funding, or jointly operating parts of a program. Conclusion: Because the Non-State Medicaid program is materially participating in the program by setting policy, partially funding the benefit, or operating parts of the program according to its own rules it is a Jointly Administered Government Program.	☐ Health Plan ☐ Health Care Provider ☐ Clearing House ☐ Business Associate ☐ Sponsor ■ JAGP ☐ Not Covered	☐ Required to Comply ☐ Compelling / Urgent Need ☐Good Business Practice ☐ Indirect Impact ☐ No Requirement / No Impact
Program Examples		
Example 1 The state Medicaid agency and Federal program (CMS) cooperate in implementing and funding the state Medicaid program.	■ JAGP	■ Required to Comply
Notes: Each program that participates in joint operations is a covered entity for the covered functions it performs. See JAGP at appendix for more information and reference.		

Interaction Model F

Program with Medicaid Interaction	HIPAA Entity Status	Compliance Status
Jointly Administered—No Transactions or Health Information Description: The program is outside of the Medicaid Entity. The program develops benefits policy for a benefit that is jointly funded by the program, the State Medicaid administration, and Federal Medicaid matching funds. The claims are received, administered, and paid by the State Medicaid program. The program transfers funds to the State Medicaid program to fund the benefit but does not conduct any HIPAA covered transactions. Conclusion: Because the program is setting policy and partially funding the benefit with a Medicaid entity, the program fits the definition of a Jointly Administered Government Program (JAGP), but is not covered because it is not performing any covered functions.	☐ Health Plan ☐ Health Care Provider ☐ Clearing House ☐ Business Associate ☐ Sponsor ☐ JAGP ■ Not Covered	☐ Required to Comply ☐ Compelling / Urgent Need ☐Good Business Practice ☐ Indirect Impact ☐ No Requirement / No Impact
Program Examples		
Example 1 *The DOH Trauma Reimbursement program sets policy and provides partial funding for the program benefit. Eligibility is determined by DSHS(Medicaid Agency). An MAA, MI, or GAU client is eligible for trauma reimbursement benefits. When one of these clients is admitted for trauma services, the hospital (and other healthcare entities) are eligible for enhanced reimbursement for covered trauma services. Claims are administered and paid through MAA.*	■Not Covered	■ No Requirement/ No Impact

Notes:
This program is an example of Jointly Administered Government Program, however because the non- Medicaid program does not participate in any transactions and does not receive any health information, the program is technically not covered, because it is not performing any covered functions. Therefore, it does not have any HIPAA implications. This is an unusual case, generally there will be coverage for both programs because some covered function relating to transactions or protected health information, as in Model E, are occurring in both programs.

Interaction Model G		
Program Located within Medicaid Agency	**HIPAA Entity Status**	**Compliance Status**
Program Located within Medicaid Agency, No Medicaid Funding or Participation Description: State program is located in the designated state Medicaid Agency, but does not conduct any Medicaid business. No Medicaid or other named health plan funds are used. Conclusion: The state program is not a covered program simply by being located in the same agency as the Medicaid agency. Independent analysis of the program's purpose and functions is required.	☐ Health Plan ☐ Health Care Provider ☐ Clearing House ☐ Business Associate ☐ Sponsor ☐ JAGP ■ Not Covered*	☐ Required to Comply ☐ Compelling / Urgent Need ☐Good Business Practice ☐ Indirect Impact ☐ No Requirement / No Impact
Program Examples		
Example 1 State division of vocational rehabilitation is located within the Medicaid agency but does not interact with the Medicaid administration. Vocational rehabilitation program's primary purpose is to assist persons with a disability in finding employment. Medical evaluations and some medical services are paid by the program to further this purpose. No Medicaid or other named health plan funds are utilized. The program meets a health plan exception because its primary purpose is not heath care, it is employment. However, it may still have indirect impacts because the providers they do business with are covered and may demand changes or stop doing business with the program.	■ Not Covered	■ Indirect Impact
Notes: *Whether the program is a covered entity is not dependent on the location of the program within any particular agency or administration. For this model, the entity status of the program will be dependent on the program's other business functions and funding sources. See example for a program analysis.		

Interaction Model H

Program with Local Government Interaction	HIPAA Entity Status	Compliance Status
Grant Award Description: State program allocates grants to local governments to carry out a program with an array of defined services under a grant that is based on cost reimbursement. The local government may subcontract some or all of these services. Grant covers administration costs, outreach, support services, treatment, etc. No Medicaid or other named health plan funds are used. Providers enter information about services rendered to individuals into state client tracking services. Grants are monitored by state program based on aggregate number of services provided. Conclusion: The state program is performing the function of a sponsor of a government benefits program. Government benefit sponsors are not automatically exempt from HIPAA. However, this program meets the health plan exclusion because its principal activity is the making of grants to fund the direct provision of health care to persons. The local government may be both a health plan and/or health care provider.	☐ Health Plan ☐ Health Care Provider ☐ Clearing House ☐ Business Associate ■ Sponsor ☐ JAGP ☐ Not Covered	☐ Required to Comply ☐ Compelling / Urgent Need ☐Good Business Practice ☐ Indirect Impact ☐ No Requirement / No Impact
Program Examples		
Example 1 State alcohol and substance abuse program contracts with counties to provide outpatient services, outreach, referral, support and other services. The county bills the program monthly using a paper claim on a cost reimbursement basis. Providers input treatment information into a state system. The primary purpose of the state program is to disburse and oversee the administration of the grants.	■ Sponsor	■ Indirect Impact

Notes:
While sponsors of government benefits are generally not excepted from HIPAA requirements, this program meets the health plan exclusion, and thus is not required to comply. Other programs who do not meet the health plan exception will be functioning as a sponsor, and required to comply with health plan requirements because a sponsor meets the broad definition of a health plan under “otherwise pays or provides the cost of medical care.” Since the program is interacting with covered entities, the exchange of information from the covered entity must still comply with HIPAA, and this could impact data content, format, and delivery methods.

The counties, on the other hand, may be health plans and/or providers. As health plans, counties may also meet an exception to the health plan definition because a county’s primary purpose may not be health care. As providers, counties would be subject to HIPAA if they perform electronic transactions. Even if counties do not conduct any electronic transactions as a provider, the county may have indirect impacts because it does business with covered entities.

APPENDIX

The appendix provides a more in depth description of Key Terms found in the Model and an overview of HIPAA implications for the various status terms. The overview is not intended to be comprehensive, but to identify key requirements imposed by the regulations. The terms are grouped by the categories as found in the model.

Entity Status

Health Plan: Health Plans are an individual or group plan that provides, or pays the cost of, medical care.

(1) Health plan includes the following, singly or in combination:

a. A group health plan, as defined in this section
b. Part A or Part B of the Medicare program under title XVII of the Act.
c. The Medicaid program under title XIX of the Act, 42 USC 1396
d. An issuer of a Medicare supplemental policy
e. The Indian Health Service program
f. An approved State child health plan under title XXI of the Act,
g. The Medicare + Choice program under part C of title XVII of the Act
h. A high risk pool that is a mechanism established under State Law to provide health insurance coverage or comparable coverage to eligible individuals, (see regulation for other non-state related categories).

Health plan exception: programs that pay excepted benefits and government funded programs not listed above whose principal purpose is other than providing, or paying the cost of, health care; or whose principal activity is the direct provision of health care to persons or the making of grants to fund the direct provision of health care to persons. §160.103. See also exceptions at 65 CFR 82479, 82578.

Implications Overview: Health plans must have the capacity to conduct transactions in compliance with the standard. Health plans can choose to have a clearinghouse perform some or all transactions on their behalf, and/or modify or replace existing systems used for payment and administrative functions subject to the standards. Health plans can choose to continue to accept paper or alternate non standard transactions in addition to having the standard capacity. Health plans may not alter or add to the standards and cannot charge additional fees or otherwise delay, reject, or adversely affect the transaction. The standards also eliminate the use of “local” codes. Health plans must comply with privacy and other regulations as finalized. Privacy requires health plans to inform patients of their information practices, and get specific authorization for uses and disclosures other than treatment, payment or health care operations. Privacy mandates that patients have access to their records, can request amendment, and receive an account of most disclosures made. Privacy requires the provider to limit use and disclosure of protected health information to the minimum necessary to accomplish the purpose, except for treatment. Appropriate physical and technical safeguards must be in place to protect the information. Privacy requires establishment of a privacy official and training of workforce members.

Health Care Provider: Health care providers are any person or organization who furnishes, bills, or is paid for medical or health services, or health care in the normal course of business. To be covered, a health care provider must also transmit any health information in electronic form in connection with a standard transaction. §160.102 and §160.103.

Implications Overview: Covered health care providers may choose to send transactions via paper, fax, voice-response, or direct data entry if offered by the payer. These transmission modes do not have to be fully HIPAA compliant. However, electronic transmissions must be conducted in a HIPAA compliant manner or sent to a clearinghouse. A provider must comply with privacy and other regulations as finalized. Privacy requires providers to inform patients of their information practices, get consent prior to use of health information for treatment, payment and health care operations, and get specific authorization for most other disclosures. Privacy mandates that patients have access to their records,

can request amendment, and receive an account of most disclosure made. Privacy requires the provider to limit use and disclosure of protected health information to the minimum necessary to accomplish the purpose, except for treatment. Appropriate physical and technical safeguards must be in place to protect the information. Privacy requires establishment of a privacy official and training of workforce members.

Clearinghouse: Clearinghouses are public or private entities that process or facilitate processing of health information received from another entity. The clearinghouse receives health care transactions from health care providers or others, translates the data from the given format into one acceptable to the intended payor or other, and forwards the processed transaction. Clearinghouses include billing service, repricing company, community health management information system, or community health information system, and "value-added" networks and switches when performing the above functions. §160.103 Note: a clearinghouse must perform the functions of format translation or data conversion to be covered under HIPAA. 65 CFR 50319.

Implications Overview: For those transactions the Clearinghouse performs, it must translate data in compliance with the standard. Clearinghouses must comply with privacy and other regulations as finalized. Privacy requirements for clearinghouses are limited when the clearinghouse is performing services on behalf of another covered entity. §164.500(b) In that case, clearinghouses are required to comply with their business associate contract, limit use and disclosure to the minimum necessary, and disclose information for very limited purposes (ie: required by law, see §164.512). If clearinghouses are acing on its own behalf, then all privacy rules apply.

Business Associate: Business associates are persons or entities who, on behalf of a Covered Entity, perform or assist in an activity involving use or disclosure of individually identifiable health information or any other function or activity regulated by the HIPAA rules or provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services where such services involve disclosure of individually identifiable health information. §160.103 A Covered Entity may be a Business Associate of another Covered Entity.

Implications Overview: A business associate is not directly regulated unless it is also a covered entity. However, covered entities who use business associates must require business associates to comply with HIPAA regulations as a condition of doing business with them. Business associates must comply with regulations applicable to the functions it performs for the covered entity and require any agent or subcontractor to comply. §162.923. Privacy regulations require that a business associate contract contain specific provisions basically mirroring the covered entities obligations. The contract must specify the permitted or required uses and disclosures and prohibit all others; require appropriate safeguards; require reports of inappropriate uses; comply with provision allowing individual access; make records and books available to HHS for inspection; and provide for return or destruction of protected health information at contract termination. §164.504(e)

Sponsor: Sponsors are discussed in numerous places in the official comments to the transactions and privacy regulations. A definition is found in an implementation guide as follows: is the party that ultimately pays for the coverage, benefit, or product. Can be employer, union, government agency, association, or insurance agency. In contrast, a payer is the party that pays claims and/or administers the insurance benefits. Payers can be insurance company, HMO, PPO, government agency, or other contracted organization. 834 Implementation Guide.

Implications Overview: Sponsors are generally not covered entities: We recognize that entities that are not covered under HIPAA, such as sponsors of health plans, including employee welfare benefit plans, are not require to use the HIPAA standards …65 CFR 50337. However, if the entity is otherwise covered, the fact that it performs sponsor functions does not except it from HIPAA, for example: A State Medicaid program is acting as a sponsor and is excepted from the HIPAA standard requirements only when purchasing coverage for its own employees. The state Medicaid program is not acting as a sponsor when enrolling Medicaid recipients in contracted managed care health plans, and this is not

excepted from the law. 65 CFR 50338. Thus, entities paying for medical care (health plan) must comply with HIPAA regulations, except for "sponsor" transactions with respect to employees.

JAGP: Jointly Administered Government Programs are discussed in several places in the official comments that accompany the privacy regulations. This "entity" is basically an exception to both the business associate rule (sharing information between the joint programs allowable without a contract) and the health plan rule (the program is only "covered" to the extent of the covered functions it performs).

We also include an exception [to the business associate rule] for certain jointly administered government programs providing public benefits. Where a health plan that is a government program provides public benefits, such as SCHIP and Medicaid, and where eligibility for, or enrollment in, the health plan is determined by an agency other than the agency administering the health plan, or where protected health information used to determine enrollment or eligibility in the health plan is collected by an agency other than the agency administering the health plan, and the joint activities are authorized by law, no business associate contract is required with respect to the collection and sharing of individually identifiable health information for the performance of the authorized function by the health plan and the agency other than the agency administering the health plan. 65 CFR 82504. See also 65 CFR 82578.

Not Covered: Either the program description does not meet any other description or specifically meets an exception to the definition of one of the entities. (Example: a provider provides health care but does not transmit health information in connection with a standard transaction; or the program pays for medical care (health plan), but meets the exclusions for government funded program which pays directly by grant or the primary purpose is not health care.)

Compliance Status

Required to Comply: The Program is a covered entity, so compliance with the applicable HIPAA regulations is required by law. (Example: The program is a Health Plan because its primary purpose is paying for medical services.)

Compelling / Urgent Need: The Program is not a covered entity, but may be unable to continue to conduct program business functions if it is not compliant with some or all of HIPAA. (Example: Workers compensation (L&I) is excluded from the definition of a health plan but transacts with health care providers who are covered. Health care providers may choose not to do business with the program if L&I cannot accept standard transactions.)

Good Business Practice: The program is not a covered entity, but is impacted by HIPAA due to relationships with others. The business functions may still continue, but will not comply with industry standards or public expectations. (Example: A program that performs independent data analysis, but the final report is compared, used, or combined with data analysis from an HIPAA covered entity. The data elements would have to be cross-walked or may not match up.)

Indirect Impact: The program is not a covered entity, and the business functions or process will probably not change due to relationships with others. However, data content or other elements may change. (Example: A government program may collect eligibility information which is passed on to a government health plan. The function can continue, but the data forwarded may change due to the health plan's needs to comply with HIPAA data elements.)

No Requirement - No Impact: The program is not a covered entity and the business functions are not impacted by internal or external process changes that may occur due to HIPAA.